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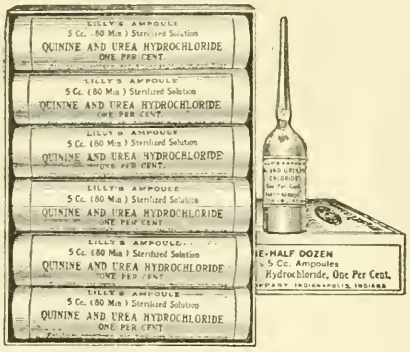

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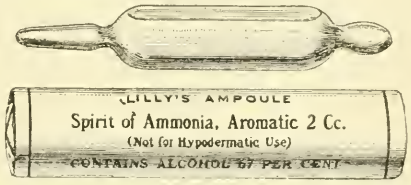

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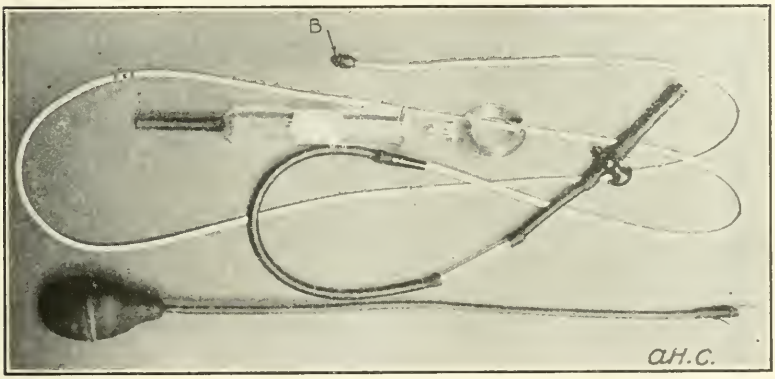
THE DUODENAL TUBE—A BRIEF DISCUSSION REGARDING ITS USE AND VALUE, WITH REPORTS OF CASES.

By Albert Hynson Carroll, M.D.,
Associate in Diseases of the Stomach and Intestines, University of Maryland.



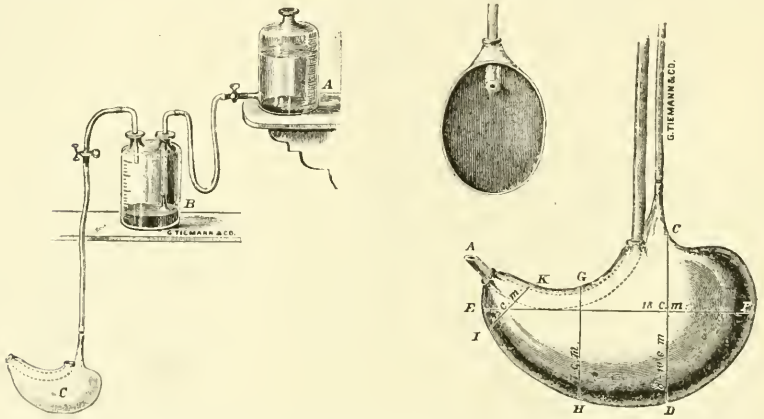
EINHORN'S DUODENAL TUBE, WITH THE GLASS SYRINGE.

To be able to penetrate into the digestive tract as far as the duodenum without pain or real discomfort to the patient, and to withdraw its content for analytical study, sidetracking the stomach and the esophagus, resting these parts when this is indicated, and allowing of the introduction directly into the duodenum of food or of therapeutic agents, is indeed an achievement which marks distinct progress in the treatment and in the diagnosis of disease.

So readily can the method be comprehended and put into practice with the duodenal tube that there is but little excuse for the practitioner who does not arm himself by becoming familiar at least with its principal uses and the technique.

It is surprising that more space has not been devoted to the new method in the medical journals. However, the literature to date, altho not great in volume, is rational, and is readily comprehended. There has been a delightful absence of false and ungrounded claims made for it. Max Einhorn, who gave us the tube, is perhaps the most modest of any of those who are using it in his claims for its merits.

With a broader knowledge of its value, the tube will, without doubt, become a part of the kit of many practitioners, who at present condemn it outright, or simply pass it over with a wave of the hand. To these it means nothing at present, and will not, unless either the prejudice which is inborn in them to any new procedure is overcome, or a broader acquaintance with the mechanics of digestion, with physiological processes, and with the repair of lesions of the upper part of the digestive tract is acquired.



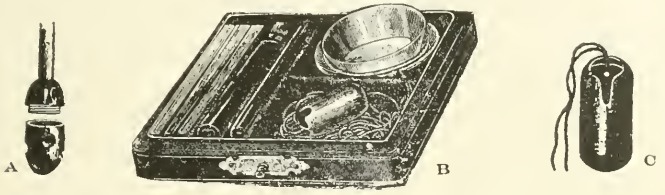
Original apparatus devised by Hemmeter and used in securing duodenal contents. Pressure bottles for distending intragastric rubber bag, and semi-diagramatic cut of the bag showing the directing groove for the slender intubating tube. An advantage of this early method is that when necessary intubation can be accomplished in a few minutes.*

For a long time studies had been carried on with gastric secretions, and gastric juice was a familiar object in the laboratory. Appreciating fully that digestion only began in the stomach, there was naturally a keen desire to investigate the enzymic activities of the contents of the upper part of the intestine, for it is here that the food residue from the stomach comes directly into contact with the copious secretions poured out by the liver and the pancreas. To do so it was necessary to secure the duodenal content under as nearly physiological conditions as was possible, and intubation was the only solution of the problem.

With this object in view, Hemmeter[1] as early as 1905 devised and used an elastic rubber bag with a directing groove, which he introduced into the stomach. When the bag was in-

*Diseases of the Stomach.—Hemmeter.

flated its walls approximated the walls of the stomach, and he was able to pass a slender rubber tube through the directing groove and on into the duodenum, and to aspirate its contents.*



A. Olive-shaped perforated metal end piece of the duodenal tube. It can be unscrewed for cleaning.

B. Bucket with a lid so arrranged that it will close when traction is made on the string, with reagents and a tray. This outfit is interesting as representing a stage in the development of this effort to secure gastric and duodenal contents for study.

C. An enlargement of the "bucket" showing the ingenious self-closing lid. At best only a small amount of material can be secured, and this may be contaminated.

The next attempt to invade the duodenum was made by Einhorn in 1908, with that ingenious little contrivance, the duodenal bucket.[2] The bucket was supplied with an automatically-closing lid, which did not, however, prevent frequent contamination of its contents when it was being used. It is of use in diagnosis only, and with it but a very small amount of the secretions can be obtained. The ease with which the bucket could be gotten into the duodenum, being carried there by peristaltic movements of the stomach, no doubt suggested that a slender rubber tube be substituted for the thread, and that the bucket be supplanted with a perforated metal extremity, and about a year later Einhorn gave us the method of intubating the duodenum with his duodenal tube.[3]

This consisted of a slender rubber tube 0.2 c.m. in diameter and 90 c.m. in length, attached to an olive-shaped and perforated metal capsule. The tube as now used is marked at 40 cm., to indicate when the bulb has reached the cardiac orifice, at 56 cm., the pylorus, and at 70 and 80 cm. When the 70 cm. mark has reached the incisor teeth the bulb should be *in situ*.

The proximal end is provided with a two-way stop-cock, and a glass syringe is used for aspirating the contents.

Gross[4] devised a similar apparatus almost simultaneously. It differs only in that he has marked his tube at every 10 cm. and has placed a receiving bulb in the tube between the mouth and the syringe. It is 125 cm. in length. The tubes are essentially the same.[5]

When Kussmaul, in 1873, introduced gastric lavage into the-

*It is a matter of interest to recall that it was Hemmeter who first suggested photographing the human stomach with the bismuth X-ray method, the development of which has enlightened us as regards the true shape of this organ. See Hemmeter, "Photography of the human stomach by the Rentgen Rays." Boston Med. and Surgical Jour., 1896.

rapeutics by extending the use of the stomach tube, a step forward was made. Shortly after this Leub found further use for it, and demonstrated that the tube was of value in diagnosis, as well as in the treatment of disease. So it was when Einhorn first gave us his method of alimentation. Immediately many new possibilities became evident, and new uses were discovered for it not only in treatment, but in the field of diagnosis as well. Space will prevent my going at all thoroughly into the subject, but I shall indicate some of the conditions in which the tube may be used with advantage, and following a brief description of the technique of the introduction I will venture to place on record several new cases in which the value of the tube in diagnosis and in treatment was beyond question, hoping that this will stimulate some of my readers to a more general interest and use of this recent addition to our armamentarium.

With the tube duodenal secretions can be secured for a study of their enzymic activities, and for the presence of blood.[6] If no blood has been found in a previous examination of gastric contents, and it is found in the duodenum, we may look upon the tube as an instrument of precision. In several cases where the location of an erosion was a matter of doubt, I have been able to positively state before operation that we were dealing with a duodenal ulcer. Three of these cases were operated upon by Dr. Frank Martin, and a pylorectomy done. In two cases the laboratory report was beginning carcinomatous changes. When it is remembered that the duodenal erosion has not been generally regarded as a seat for future cancerous growth, it appears to me that to be able to at times definitely state the location is a matter of some interest.

The study of the enzymic activities of the duodenal content does not appear to be one of academic interest only. Much remains to be done in this line of investigation before we will be able to draw many definite conclusions from the studies. However, we are able to tell if the duodenal content is potent as regards the digestion of fat, of starch and of proteid, both quantitatively and qualitatively.

The studies of Hertz, of Cannon and others, with the aid of the X-ray, have given us a fair idea of the normal rate of progress of the food residue through the several anatomical divisions of the digestive tract.[7] Hence, in any study of the stool it appears to me that if we know just how long the food residue takes to traverse the stomach, to pass through the small intestine, and to reach the pelvi-rectal flexure, and supplement this with the information we can secure from a study of the activities of the secretions of the stomach and of the duodenum, we will be in a position to better interpret the stool picture. If it is true that cellulose disappears under prolonged bacterial action in the bowel, we can

conceive readily how we may go astray on stool examinations unles we co-ordinate the information above referred to.

Zeisler sums up well when he stated that we are living in a period today when the pathological laboratory has become indispensable to us in our work, but we should not use it in the pursuit of fads; we should not forget that, alter all, the laboratory should be our aid, our assistant, not to say our servant, and not our master. The methods of investigation have been quite well worked out in regards to the action of the various enzymes. It remains, however, for us to learn to piece together the information in order to form the picture we wish to read. Although such laboratory studies are of intense interest, it is the less difficult and more practical uses of the tube which we are interested in calling attention to in this short paper.

Without doubt the very greatest use the tube can be put to is in duodenal feeding, where, for any reason, it is necessary to nourish the patient, and yet spare the tract from the irritation of food, either in passing through the esophagus, the stomach or in the duodenum. With these parts put at rest an ulcerated or eroded area is given the best opportunity to heal, since the tube sidetracks the diseased area. The use of it in the treatment of ulcer alone would warrant its existence.

Lenhardt, Osler, Kemp, and in fact all clinicians, appreciate the fact that the ideal treatment as regards furthering the healing of an ulcer is to put the part at rest. And yet, no doubt, we are dealing with more than ulcer alone when we treat these cases, and it now appears that we have good grounds for thinking that an ulcer is only a manifestation. That after all we are confronted with "*gastric or duodenal ulcer disease*," and as there is no specific treatment, the patient must be nourished and put in as good condition as possible to combat or aid in the return to a normal state.

But food in the stomach in sufficient quantities to supply the normal demands of the body not only distends the gastric bag, but by its very presence *stimulates peristalsis and gastric secretions*. Furthermore, if we distend the walls of the bag, we may also stretch the base of a healing erosion. The duodenal tube allows of the delivering of food and therapeutic remedies distal to the pathological area. We sidetrack it and rest it.

At times we wish to lavage the duodenum in so-called catarrhal jaundice. Recently Jutte has called attention to another possibility of the duodenal tube, in what he has termed transduodenal lavage. "This is to the small intestine what enema is to the colon." From 1000 to 1200 c.c. of normal saline solution is employed by the drop method in intestinal toxemias with their many-sided sequelae and the various types of catarrhal enteritis. Einhorn has reported a series of cases of acute conditions of the liver, where he found that with duodenal feeding the hepatic congestion disappeared rapidly. Ipecac can be placed directly into the duodenum in cases of amebic dysentery with excellent results.

The progress of the patient when under treatment for disorders which are evidenced by disturbances in the gastric secretions, can be studied from day to day, with much less inconvenience to the patient and without the confusion which often arises from regurgitated duodenal secretions when the stomach tube is used. I refer to those patients who suffer from irritable throats or who, from other causes gag and retch when the stomach tube is used, and in this way return duodenal alkaline secretions into the stomach.

It is but seldom that a patient is met with who finds the slender tube either difficult to swallow or irritating. It is truly remarkable with what readiness they learn to retain the tube indefinitely, and the lack of discomfort experienced.

In certain cases where there is a persistent reflex vomiting, due to inflammation which has extended to the duodenum, as in gall bladder disease, the use of the tube may be the only means by which the vomiting can be checked. The first case reported well illustrates this point.

In pylorospasm and in spastic conditions of the esophagus or of the cardiac orifice of the stomach, feeding can be carried out once the bulb has passed the spastic area. With one tube in the duodenum a second tube may be placed in the stomach where there is a gastro-succorrhea and the hypersecretions siphoned from the gastric bag. I have only tried this in a few cases, and altho the procedure appears to me to be worth the trial, I have not as yet used it in a sufficient number of cases to warrant any statement as to the practical advantage of the method.

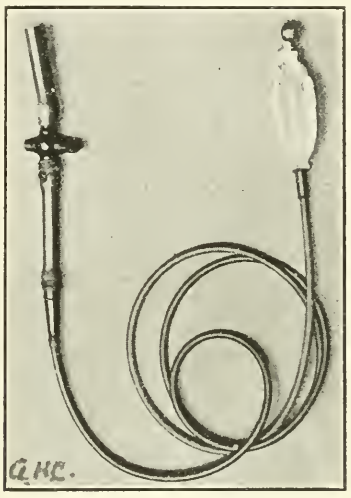
Technique of introduction:[8] The object to deliver into the duodenum the perforated globular extremity of the tube. The technique is simplicity itself. There is seldom any choking on the part of the patient, and only a moderate degree of patience is required by the investigator.

The bulb is placed well back on the patient's tongue, and he may be given a few mouthfuls of water to aid its passage into the stomach. No other lubricant is required. The patient should breathe through the mouth until the tube has entered the stomach. He is now told to lie on his right side. It is well to gently direct or guide the tube into the mouth, but no effort should be made to force it, as this will surely result in a doubling up of the tube. In guiding the tube you will overcome any traction which might occur if it is allowed to hang down or drag on the patient's clothing.

When the first mark has reached the incisor teeth we know that the bulb should be entering the stomach. It is my rule to aspirate some gastric content at this stage for study and for comparison with the contents of the duodenum, to be secured later.

After having withdrawn the gastric specimen *fill the tube*

with water and turn off the cock, allowing the tube to hang down over the edge of the bed, after securing the tube near the third mark to the cheek with adhesive. When the third mark has reached the teeth, the cock may be opened and duodenal content, in nearly every case, will siphon from the tube. Frequently while watching patients after the tube has been swallowed and the cock left open, I have been able to *tell exactly when the tube has reached the duodenum* by observing the change of color in the fluid dropping from it, from a colorless to an orange-green. The texture of the fluid also at once proclaims it to be duodenal rather than gastric content.

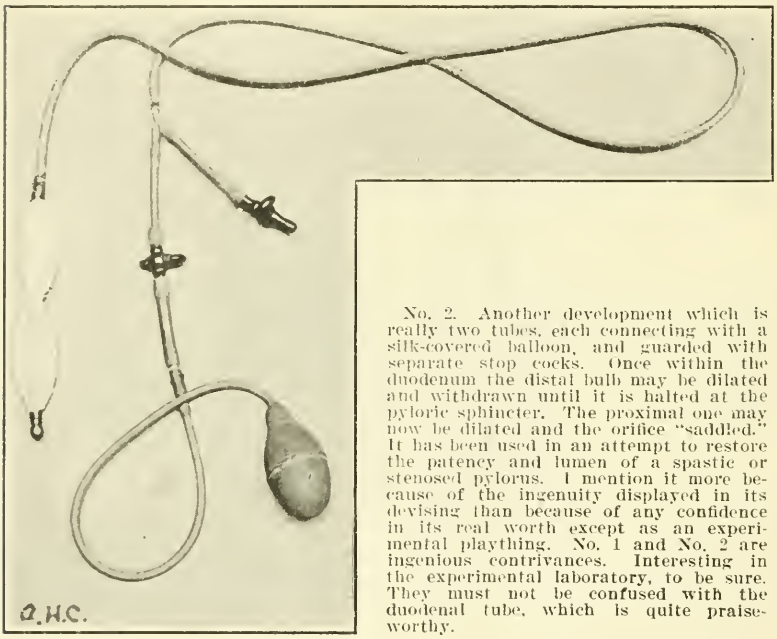


No. 1. This is a duodenal tube with a balloon attached to its end. When in the duodenum it can be dilated. Its real use has as yet to be proven except perhaps as a means of locating the pylorus and experimentally determining its patency. With it a spasm may at times be differentiated from a partial obstruction. It has been used in an attempt to relieve the former condition. Such a contrivance may be utilized in duodenal transillumination. Experimentally interesting, but in my opinion of little value.

This knowledge of the time required for the stomach to pass the bulb into the duodenum must not be overlooked, as it may serve as an indicator to the peristaltic activity of the stomach.

Occasionally the tube will become doubled up in the stomach, and the bulb not enter the duodenum. A drink of milk may be given as a test, and if this can be aspirated immediately, the tube must be partly withdrawn and another attempt made. In a certain percentage of cases real or imagined difficulties to the passage of the tube into the stomach are met with. When the difficulty is not in the nature of a true obstruction, the tube may be threaded on a flexible director. On one occasion I was compelled to borrow a piece of wire from the patient's electric doorbell, and when the insulation was removed it served its purpose very well.

As previously mentioned, the filling of the tube with water after it reaches the stomach, and allowing it to hang at a lower level than the patient, will often obviate the necessity of using the aspirating syringe, and the siphoning of the content will begin and continue after the stop-cock is opened. However, when this does not come about the process may be initiated with the syringe, but only a gentle vacuum must be created. Otherwise the tube will collapse at the most compressible portion, and this will result in suction distal to the collapsed portion being done away with.



No. 2. Another development which is really two tubes, each connecting with a silk-covered balloon, and guarded with separate stop cocks. Once within the duodenum the distal bulb may be dilated and withdrawn until it is halted at the pyloric sphincter. The proximal one may now be dilated and the orifice "saddled." It has been used in an attempt to restore the patency and lumen of a spastic or stenosed pylorus. I mention it more because of the ingenuity displayed in its devising than because of any confidence in its real worth except as an experimental plaything. No. 1 and No. 2 are ingenious contrivances. Interesting in the experimental laboratory, to be sure. They must not be confused with the duodenal tube, which is quite praiseworthy.

It is interesting to note the irregular dropping of the content from the end of the tube. When all is going well the dropping will become at rythmic intervals almost a continuous stream. This alteration in the continuity of the flow is largely dependent on the alteration in the intra-abdominal pressure accompanying the respiratory act. We can often secure an additional amount of duodenal content by having the patient take a deep breath when it has ceased to siphon and when the aspirating syringe fails to withdraw a further amount. I think that there is an increase of pressure on the very compressible tube at the sphincters, and when a partial vacuum is created it collapses at such a point. Frequently a tenacious mucous material will siphon through the tube, while any attempt to aspirate it will result in complete failure through the *collapse of the tube*.

BRIEF REPORT OF CASES TREATED WITH THE DUODENAL TUBE.

Case No. 1—Hospital No. 1234; Mrs. J. E.; age, 43; entered hospital April 23, 1913; left hospital June 12, 1913.

As regards past history, there is nothing which sheds any light on the present trouble. The patient has been a very healthy woman all her life. She was perfectly well up to several weeks before *being carried into the hospital,* and for two months prior to the onset of the present trouble she had nursed three children ill with typhoid fever. Two weeks before entrance she developed acute pains in the epigastric region, and thought she had "acute indigestion." The pain became almost constant, and there was great tenderness in the upper right quadrant also, but there was only an occasional attack of vomiting for the first week.

She was under the firm conviction that she had contracted typhoid from the children. Six days before entrance she began to vomit after *each attempt to take food or water.* She says the vomited matter was nearly always greenish, and that it made her "burn like fire" in the esophagus and stomach. Every time she swallowed there was an intense burning sensation in the throat and esophagus. She was "famished for want of a drink of water." Her mind was perfectly clear at all times. An ice bag over the upper abdomen gave but little relief. She had been a stout woman, and there was still much adipose tissue. There was pressing need for supplying fluid to the tissues.

The patient's family physician had diagnosed gallstones early in the attack. During the blood examinations a Widal was made. This was positive. Two later tests were also positive.

I did not see the patient until five days after she had been brought into the hospital, when I was called in consultation by Dr. Randolph Winslow. Proctoclycis had already been instituted, and had been persevered with, although the patient was retaining only a small amount. *The vomiting occurred after every effort to ingest food or fluid.* The vomiting matter was bile-stained, and consisted mostly of ropy mucus. It was negative to visible or to occult blood. More fluid was being ejected than we were able to introduce.

Bismuth was given several times before a sufficient quantity was retained long enough to secure an X-ray examination. Finally two plates were secured. The immediate plate showed the stomach to be in active peristalsis. Some bismuth had already entered the duodenum. The one-hour plate discovered the stomach to be completely empty, and the bismuth was well on its way to the cecum. There was no evidence of adhesions around the pyloric end of the stomach, nor was the pylorus drawn over to the right.

This was evidently a case of duodenal spasticity, probably secondary to gall bladder disease, with a regurgitation of contents into the stomach.

Here was an opportunity to furnish fluid and food to a famishing person, provided the spastic area could be sidetracked with

the duodenal tube. It was a matter of doubt if the tube could be introduced and the bulb passed beyond this spastic area.

The possible typhoidal condition had to be borne in mind, and yet there was no doubt that an exploratory operation was indicated. The condition of the patient's heart and her general state forbade even the giving of an anesthetic at this time. Pulse, 120; respiration, 24; slight discoloration of the sclera; hemaglobin, 65; whites, 6000; reds, 4,000,000.

Her mind remained perfectly clear during the entire illness. Her suffering was intense at times. She was a very ill woman.

After persistent efforts the duodenal tube was retained, and passed on into the duodenum. Almost pure bile in quantity was secured. Feeding was at once begun. For three days the tube could be retained for only a few hours at a time. After the third day it would stay in place over night. The patient was given egg albumin, peptonized milk, beef broth and water at two-hour intervals up to 2800 calores a day. After the fifth day she did not vomit, and her improvement and gain in strength was truly interesting. The fourteenth day her hemaglobin was 80; reds, 4,500,000; whites, 9000; pulse, 90; respiration, 20. She was taken to the operating room, and was operated on by Dr. Randolph Winslow. Several stones were removed from the gall bladder, and about 250 c.c. of pus was evacuated. Four weeks later the patient left the hospital a well woman. * * * * *

Although the X-ray examination was a matter of rather good fortune, and was not an ideal one, it served to demonstrate that there was a duodenal irritation; that the stomach was hypertonic; that active peristalsis was present; that there was a rapid emptying of that organ when its content was not vomited. Here were three of the four conditions forming the symptom-complex which Hertz[9], Rowden[10] and Barclay[11] and others hold to as diagnostic of duodenal irritation. The fourth is lacking in this case. "Food was not seen passing through the duodenum, with or without a persistent shadow in some part of the duodenum." Had a fluoroscopic examination been possible, this point also would, no doubt, have been added.

The point is this: Had it not been possible to build up this patient with duodenal feeding, she could have survived but a few days. An imperative operation could not have been performed in her condition on entrance, and there is no reason to believe that the vomiting would have ceased or could have been otherwise controlled. All usual efforts had been attempted for five days before I was called in by Dr. Winslow, with no success whatever. The duodenal tube *solved the problem.* Simon has recently reported two very similar cases.[12]

Case No. 2.—This case illustrates the use of the tube in a selected case where the object in view was *not to cure the patient,*

or to aid in any way, except from the symptoms of pressure due to acute dilation and an obstructive condition.

Six days after an apparently clean operation for appendicitis symptoms of acute dilation and obstruction began and rapidly became marked. The pressure symptoms from the distended gastric bag became rapidly worse. For several days the stomach was emptied of its contents every two hours with the stomach tube. Some relief from the dysponea and intra-gastric pressure lasting but a short time, followed. The usual efforts were made in this case to bring about a change without avail. The patient was away from home, and it was not thought wise to open the abdomen again without consulting with the family, and for other good reasons. She was in extremis. The passing of the stomach tube was in itself a dangerous tax on the small store of vitality. *Circumstances prevented* even this method *for a period*, and at this time it appeared to me that if the duodenal tube could be gotten into the stomach, *constant siphonage* would follow, and the contents would be removed *as soon as they had appeared* in the bag. This was done, and the tube remained in place from the first, *i. e.*, from 12 M. until 9.30 P. M., when the abdomen was opened.

The content was slightly yellowish the first hour or so, and flowed in an almost constant stream. About two liters were collected the first four hours. A quantity of gas was also liberated. Later the siphoning content became rapidly fecal in odor, much darker in color, and without doubt contained disintegrated blood. The patient's respiration was less labored than at any time, except immediately after evacuation by the stomach tube, before its use was interrupted. The pulse, though alarming, became fairly constant in tension and rate. The patient undoubtedly went to the operating-room in a far better shape than if she had increasing distention and pressure up to *the maximum* of capacity and endurance to fight with, each two hours. In other words, we furnished more room, and maintained a state of lessened intra-gastric pressure, which was then equal to the pressure which had to be contended with immediately following the intermittent stomach tube evacuation.

Case No. 3.—Patient, H. L. H.; white; male; age, 27; occupation, packer. This case may be considered somewhat atypical, in as far as there were no hunger pains, and the discomfort was fairly constant. Food did not relieve the pains, which came on about two or three hours after eating. At no time did he notice that he was awakened at any time at night with pain. He had had a gradually increasing "dyspepsia," as he called it, for three years. Occasionally he would vomit about one-half hour after eating. This did not relieve the pain, which was located in the epigastric region. This was burning in character, but not severe at any time. The symptoms had not been more marked during cold weather. He had never seen blood in his vomit, but often

had noticed streaks of blood in his stools. He did not know if the stools had ever been "tarry" in color. He had been constipated for three years. He had been a very healthy, well man up to the present trouble.

The physical examination was negative as regarded the heart, lungs and urine. The blood picture was not illuminative. There was a moderate degree of visceroptosis, with a subxyphoid angle of 70°, and both tenth ribs floating. (Stiller's sign.) There was a sensitive area on pressure in the region of the gall bladder. An X-ray examination showed active peristalsis, with no bismuth in the stomach after two hours. There was no evidence of adhesions in the pyloric region. Examination of the rectum discovered a congested condition and hemorrhoids. The sigmoid was also somewhat congested. No ulceration. *Any blood found in the feces could easily have been ascribed to this source;* or to higher up in the colon.

Analysis of three test meals showed free HCl, 25 to 30°, but no blood. No retention (macroscopic) of the early meals. A Hausmann "fasting stomach test" with rice was made. Twenty c. c. was obtained, and this was *microscopically positive* for starch. Slightly bile stained. No blood.

The "string" test was negative for blood. Since the stools had appeared to be poorly digested, and to contain an excess of fat, I decided to draw the duodenal contents to test its enzymic values with the Einhorn agar-starch, agar-olive oil and agar-hemaglobin tubes.[10] The stomach had been washed clean, and a glass of boiled milk given during the introduction of the duodenal tube. In one-half hour duodenal siphonage began, and there was a flow of pinkish blood-stained fluid. The tube was withdrawn into the stomach and gastric content secured. This was blood free.

Patient operated on by Dr. Frank Martin. After exposing the pylorus and duodenum absolutely no evidence of the ulcer was found, except at one spot there was a suspicion of a slightly anemic spot just distal to the ring. This area or no other was indurated or thickened. The pylorus was patent. Pylorectomy and gastro-enterostomy was decided upon, however, as I was convinced that an ulcer was present. In making the circular incision an ulcerated area 2 to 3 sq. cm. was exposed.

Patient left hospital July 30, 1913, apparently a well man. Reported August 31. He had gained 12 pounds.

Operation was not undertaken in this case until medical means had been found of no avail. Pylorectomy, when done by a skilled surgeon, is without doubt the operation of choice. Rodman, as far back as 1906, advocated excision or pylorectomy in pyloric ulcer cases.[14] Tuffier holds that every solitary and easily accessible gastric ulcer should be extirpated.[15] Martin has operated on two cases recently for ulcer in the duodenum close to the pylorus, in which I used the duodenal tube as an aid to diagnosis. The microscopic findings were beginning malignancy.[16] In neither

case was there macroscopical or clinical evidence of the change taking place at the site of the ulcer. A strong argument for pylorectomy in this class of cases.

Case No. 4.—Mr. L. The patient had had indigestion for several years, with attacks of vomiting and definite symptoms of duodenal ulcer. He had been jaundiced frequently, but had at no time experienced a typical attack of gallstone colic. There was a marked visceroptosis. An X-ray series made by Dr. Baetjer showed marked hypermotility of intestines and active gastric peristalsis. Also apparently some adhesions in the pyloric region.

Test meals: Free HCl, 45 to 80°. Positive evidence of retention. No blood at any time except once, when bile was present. This was always the case *when the stomach tube was used.* The acidity, however, was only high as regards the free HCl when gastric contents were *aspirated with the duodenal tube.* Retching would cause a return into the stomach of neutralizing duodenal alkaline secretions. One bile-laden meal contained no free HCl and blood.

Abdomen opened by Dr. J. M. T. Finney. No sign of ulcer of stomach or duodenum. Adhesions found around gall bladder and broken down. Two small gallstones removed. Uneventful recovery. Six months later many of the old symptoms returned. April, 1913.

My diagnosis was *duodenal ulcer*, and was based on the fact that on two occasions red blood in *large amount was aspirated from the duodenum.* At operation there was found a thickened gall bladder wall and some adhesions, but not an acute inflammatory condition. I still hold from later study of this case that the blood was from a duodenal ulcer which was *not discoverable* at operation, and that the ulcer disease was distinct from the gall bladder condition; that he had two definite pathological conditions. The points I wish to bring out are these: The analysis of the gastric content was subject to error when the stomach tube was used, due to regurgitation of duodenal content and the neutralization of its free HCl. The duodenal tube brought up gastric content alone when it was used to secure gastric content, *blood and bile free.* When used to aspirate the duodenal content red blood was secured, the origin of which is an open question.

It has not been my object to enumerate all of the uses to which this little instrument can be put. I have endeavored, however, to demonstrate that it is a valuable aid in certain cases, not only in treatment, but in arriving at a diagnosis also.

343 Dolphin Street, Baltimore, Md.

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[1]Hemmeter—*Johns Hopkins Hospital Bulletin*, April, 1905, and also Boas' "Archives for Digestive Diseases." Vol. II, p. 85.

[2]Max Einhorn—"A New Method of Estimating the Permeability of the Pylorus," New York *Medical Record*, June 20, 1908.

[3]Max Einhorn—New York *Medical Record*, January 15, 1909.

[4]M. Gross—"Examination of Duodenal Contents for Digestive Purposes," *Medical Record*, New York. Vol. LXXXI.

[5]For a complete history of intubation of the duodenum see Hemmeter, J. C., "History of Intubation of the Duodenum," *Archiv fur Verdauungs*, Krankeilm, Berlin, April 17, No. 2, 1911.

[6]Sklodoski—"The Duodenal Pump in Diagnosis of Duodenal Hemorrhage." *Zentralblatt für innere Medizin*, Leipsic.

[7]A. F. Hertz—"Constipation," 1911.

[8]Technique: W. G. Morgan—"Duodenal Alimentation," *American Journal of Medical Sciences* (May). Vol. CXIII.

[9]A. F. Hertz—"Sensibility of the Alimentary Canal," 1911, p. 59.

[10]Rowden—B. G. A. Moynihan, *Lancet*, January 6, 1912.

[11]Barclay, A. E.—"Stomach and Esophagus," p. 55, 1913.

[12]"The Einhorn Duodenal Tube and Its Uses." *S. K. Simon: New Orleans Medical and Surgical Journal*. July, 1913.

[13]Max Einhorn—"Agar Tubes for Estimation of Pancreatic Ferments," October, 1912. The *Medical Record*, New York.

[14]Rodman—American Medical Association, 1906.

[15]Tuffier—Bull. et Mem. de la. Soc. de Chir. de Paris. Tome XXXV, p. 739.

[16]Martin, F.—"Gastric and Duodenal Ulcers; Operative Procedures Employed." The *Southern Medical Journal*, April, 1913.

[I wish to thank Drs. Martin and Winslow for the privilege of studying these cases previous to operation and for encouragement in this somewhat new field of work, and Dr. Maldeis and Dr. Lichtenberg for generous laboratory aid in blood, stool and gastric analyses, which lack of space prevents incorporating in this type of report in full.]

STUDIES CONCERNING GLYCOSURIA AND DIABETES. By Frederick M. Allen, A.B., M.D. Boston: W. M. Leonard. 1913.

The above mentioned book represents three years' work in research in the Laboratory of Preventive Medicine and Hygiene of the Harvard Medical School.

Up to the present Allen's contribution on diabetes are the most important in the English language and will stand as a model for future investigators for years to come. He has covered the field systematically as well as scientifically, and seems not to have left a stone unturned or a possible avenue of investigation untouched in making the monograph as complete as human labors can. One need only to superficially glance at the book to realize instantly the amount of energy he expended in getting his material together. The experimental part of the work alone is a sufficient life labor for most men, let alone the compiling and putting into intelligent and readable form the results of these labors. Undoubtedly Allen's researches will change our ideas to a large extent concerning carbohydrate metabolism, and will go a long way to clarifying the atmosphere of the mist of confusion surrounding this very alluring disease. Nobody interested in metabolic diseases can afford to be without this book, as it is the very last word upon the subject.

ON THE REPORTING OF COMMUNICABLE DISEASES.

By C. W. G. Rohrer, M.D.,
Maryland State Department of Health.

(*Continued from September Number.*)

From the viewpoint of numbers, Baltimore county holds second place in the foregoing table; but, for all that, I can only classify the returns from this county as "good." Taking the number of cases reported (961) and comparing them, population for population, would bring Baltimore county several places lower down in the list.

The city of Baltimore, with its area of 31.64 square miles and a population numbering 558,485 souls, being a separate public health jurisdiction, is not discussed in these pages. Its Health Department, under the guidance of Dr. Nathan R. Gorter and Dr. C. Hampson Jones, is not only one of the oldest, but also one of the greatest in this country.

The populations given above are in accordance with the Federal census of 1910. Fourteen of the counties of Maryland—Allegany, Baltimore, Calvert, Caroline, Carroll, Dorchester, Frederick, Garrett, Montgomery, Prince George's, Somerset, Washington, Wicomico and Worcester—show an increase, while nine—Anne Arundel, Cecil, Charles, Harford, Howard, Kent, Queen Anne's, St. Mary's and Talbot—show a decrease over the figures for 1900.

To summarize: In the above classification but two counties—Allegany and Washington—are classified as "very good;" 11—Baltimore, Frederick, Carroll, Anne Arundel, Dorchester, Prince George's, Montgomery, Somerset, Howard, Worcester and Cecil—are classified as "good;" six—Talbot, Caroline, Kent, Harford, Calvert and Queen Anne's—are classified as "bad," while four counties—Charles, Wicomico, Garrett and St. Mary's—are classified as "very bad."

Before quitting this important section of my paper I desire to discuss briefly another feature in the work of the Maryland State Board of Health wherein it is decidedly in advance of that of most other States. I allude to the reporting of occupational or industrial diseases, which law, enacted at the legislative session of 1912, reads as follows:

THE LAW RELATING TO REPORTS OF INDUSTRIAL DISEASES.

Chapter No. 165, Acts of 1912.

SECTION 1. Be it enacted by the General Assembly of Maryland, That a new Section be added to Article 43 of the Code of Public General Laws of Maryland of 1904, title "Health," sub-title "State Board of Health," to follow after Section 5 of said Article, to be known as Section 5A, be and the same is hereby enacted to read as follows:

SECTION 5A. Every physician attending an or called in to visit a patient whom he believes to be suffering from poisoning from lead, phosphorus,

arsenic or mercury or their compounds, or from anthrax, or from compressed air illness, or any other ailment or disease contracted as a result of the nature of the patient's employment, shall send to the "State Board of Health" a written notice stating the name and full postal address and place of employment of the patient, and the nature of the occupation and the disease from which, in the opinion of the physician, the patient is suffering, with such other specific information as may be required by the "State Board of Health." If any Physician, when required by this Section to send a notice, fails forthwith to send the same, he shall be liable to a fine not exceeding five dollars. It shall be the duty of the State Board of Health to enforce the provisions of this Act, and it may call upon the local boards of health and health officers for assistance, and it shall be the duty of all boards and officers so called upon for such assistance to render the same. It shall furthermore be the duty of said State Board of Health to transmit such data to the Chief of the Maryland Bureau of Statistics and Information, who shall record said data and include the same and a summary thereof in his annual report.

SECTION 2. And be it enacted that this Act shall take effect from the date of its passage.

As occupational diseases are scarcely communicable in the ordinary meaning of the term, excepting in their relation to tuberculosis, I shall not elaborate further upon them at the present time, but shall subsequently discourse upon them more fully in a special paper.

VII. LESSONS TO BE LEARNT.

There are lessons of duty, of patience and of good-will to be learnt in the reporting of communicable diseases. Happily, the stern behests of duty are in themselves sufficient in most instances to compel physicians to report their cases. But there are still a few members of our profession who are derelict in the performance of this important public duty, and who thereby cause much disorder and confusion in the daily routine of public health work. Fortunately, these are in the minority, and I am optimistic as to the ultimate outcome, feeling sure that the delinquents will soon see the error of their way, turn from it and join the ranks of the faithful before it is too late.

Surely no conscientious physician could enjoy serenity and peace of mind if he realized that he had defied the public health laws or wilfully neglected to comply with their requirements. Such a step would be a violation of his sense of honor and justice, and out of harmony with the Hippocratic oath,[43] whose mandates he is expected to obey. Comparatively few medical schools, however, take the time and the trouble to do obeisance to this ancient code of professional ethics, of which the following is a true copy:

"THE OATH.

"I swear by Apollo the physician, and Aesculapius, and Health, and All-heal, and all the gods and goddesses, that, according to my ability and judgment, I will keep this Oath and this stipulation—to reckon him who taught me this Art equally dear to me as my parents, to share my substance with him, and relieve his necessities if required; to look upon his offspring in the same footing as my own brothers, and to teach them this art, if they shall wish to learn it, without fee or stipulation; and that by precept, lec-

ture, and every other mode of instruction, I will impart a knowledge of the Art to my own sons, and those of my teachers, and to disciples bound by a stipulation and oath according to the law of medicine, but to none others. I will follow that system of regimen which, according to my ability and judgment, I consider for the benefit of my patients, and abstain from whatever is deleterious and mischievous. I will give no deadly medicine to anyone if asked, nor suggest any such counsel; and in like manner I will not give to a woman a pessary to produce abortion. With purity and with holiness I will pass my life and practise my Art. I will not cut persons laboring under the stone, but will leave this to be done by men who are practitioners of this work. Into whatever houses I enter, I will go into them for the benefit of the sick, and will abstain from every voluntary act of mischief and corruption; and, further, from the seduction of females or males, of freemen and slaves. Whatever, in connexion with my professional practice, or not in connexion with it, I see or hear, in the life of men, which ought not to be spoken of abroad, I will not divulge, as reckoning that all such should be kept secret. While I continue to keep this Oath unviolated, may it be granted to me to enjoy life and the practice of the art, respected by all men, in all times! But should I trespass and violate this Oath, may the reverse be my lot!"

By referring to the tables showing the status of the counties of Maryland in the reporting of communicable diseases, it can readily be seen that much remains to be done in this important field of public health inquiry. A few of the counties are notoriously defective in sending in these returns, notably St. Mary's and Garrett. Wicomico is not much better.

It would be impossible to make any intelligent person believe that only three cases of measles occurred in Garrett county in the year 1912, with 1013 cases just over the line in Allegany county.[44] It would also be equally absurd to imagine that so large a county as Garrett—the largest and youngest in the State—although peculiarly free from negro population, should not have had in it throughout the entire year of 1912 a single case of whooping cough, chicken-pox, mumps, influenza or German measles.

Besides 35 cases of typhoid fever in Wicomico county, I must give that large and populous county, so prolific in colored folk, credit for one case of scarlet fever (it must have been a curiosity), six cases of diphtheria and two cases of whooping cough. We are taught that "figures don't lie," but if we are to believe the story they convey to us about Wicomico county, then that county is certainly one of the healthiest spots on the face of the globe, because not a solitary case of measles, chicken-pox, mumps, influenza, German measles, smallpox, malaria, cerebro-spinal meningitis, anterior poliomyelitis, acute dysentery or occupational disease occurred down there in 1912. It's no wonder the three or four physicians practicing in Delmar, just on the Maryland-Delaware line, didn't know enough about measles to report their cases to the Wicomico county health officer during the recent outbreak at that place.

Again, take St. Mary's county, the oldest of all and famous in the early history of the State.[45] During the entire year of 1912 nothing but 13 cases of diphtheria happened in St. Mary's. Ty-

phoid fever, according to the infectious disease returns for 1912, is unknown in that county.

I also wish to call the attention of the numerous hospitals and dispensaries throughout the State to their usual laxity in reporting cases of communicable diseases, especially the dispensaries.[46] Some time ago, when collecting data on hookworm disease in Maryland, I received the following interesting and highly suggestive letter from Mr. Hindley:

PRESBYTERIAN EYE, EAR AND THROAT CHARITY HOSPITAL,
1607 East Baltimore Street.
Baltimore, Md., February 13, 1913.

C. W. G. Rohrer, M.D.:

Dear Sir—In reply to your circular-letter relative to *hookworm disease*, we beg to say that the nature of our work at this hospital has not as yet revealed any cases. If, however, such cases are observed in future, we shall willingly comply with your request for a report.

May I suggest that there is great laxity in dispensaries generally in reporting cases of communicable disease, and that some means should be adopted to make such reports obligatory upon the doctors under whose notice they come.

Yours faithfully,
A. F. N. HINDLEY,
Registrar.

Although the physician's pathway is not always strewn with sweet-smelling roses, yet it is my pleasure and my delight to record the fact that but few shrink from the performance of their legitimate duties. Most physicians are thoroughly imbued with the proper spirit of their calling, and, consequently, exert themselves to the utmost to perform the functions of their art in strict accord with their cherished ideals. A hundred years ago when William Wordsworth (1770-1850), the principal of the "Lake Poets," wrote—

"The primal duties shine aloft like stars,
And charities that soothe, and heal, and bless,
Are scattered at the feet of men like flowers."

he probably meant, in fine, the monumental work performed willingly, cheerfully, without money and without price, by the great body of self-sacrificing physicians who, looking neither to the right nor to the left, immolate themselves completely upon the altar of professional devotion.

VIII. SUMMARY AND CONCLUSIONS.

Surely no physician who has attentively read this imperfect paper would care to face the trying ordeal of having failed to report a case of communicable disease, with all its harrowing details, its incivilities, its embarrassment and its humiliation. The State Department of Health is doing all in its power to make it real easy for a physician to comply with the law, whose machinery, when once set in motion, it is difficult to check in its onward progress.

Every day at least two or three Baltimore county infectious disease reports are sent to the Baltimore City Health Department

by the physicians in attendance. Although this is not radically wrong, it delays and complicates matters pretty considerably. Such an oversight means that Dr. Gorter must remail the card to this office, which, in turn, is compelled to make a copy of it and mail to the district health officer in whose jurisdiction the disease originated. Once more I desire to say that all cases of contagious disease occurring beyond the corporate limits of Baltimore city are required by law to be reported to the local health officer in whose jurisdiction the case or cases originate. Kindly use a separate card for each case, giving full name, address and all other data requested. Additional infectious disease cards can be obtained from the health officer or from the State Department of Health, and all for the asking.

From B. C. 1490, when Moses proclaimed leprosy a reportable disease, down to A. D. 31, when the startling announcement was made in the synagogue at Capernaum, a city of Galilee, that "Peter's wife's mother lay sick with a fever," on down to the present age and generation, the reporting of communicable diseases has been the bounden duty of physicians, parents and householders. This problem clearly brings into play the interests of the public and the medical profession, the oldest profession extant, adorned and edified by St. Luke, and even the Son of Man Himself.

Looking backward a score or more of years, I note that the hand of time hath wrought wondrous changes. This observation applies alike to the surface of the earth, to our social condition, to our manner of living and to ourselves. Industries have risen and fallen, and others have sprung up, phoenix-like, to take their places. The countryside, once so flourishing and populous, has almost been deserted owing to the influx of the inhabitants to the towns and cities. Even the practice of medicine is not what it used to be. Formerly everyone wanted the elderly physician because of his rich experience and mature judgment; now it is the young physician, fresh from the wards of the hospital and with the aroma of the laboratory permeating his clothing, who is desired.

War, pestilence and famine, the three fell destroyers of the human race, have devastated the earth from the earliest ages down to the present time, and these will continue their work of destruction and death, in the first instance, until the swords of belligerent nations have been beaten into plowshares and their spears into pruning hooks; in the second, until physicians throughout the land promptly report the first case of epidemic disease in a community,[47] and health officials are equally expeditious in instituting all necessary measures to prevent its spread. Then we also shall have averted the third great destroying factor, famine, which almost invariably follows in the wake of the first two Captains of the Men of Death.

This paper is written primarily for the country practitioners, that immense army of noble workers who form the very bone and

sinew of our profession, and from whose ranks have come such honored names as Edward Jenner, Robert Koch, Samuel D. Gross, J. Marion Sims, Ephriam McDowell, D. Hayes Agnew and a host of others. My heart goes out unto these tireless messengers of hope and healing and good-will,[48] and all the more so when I behold the fabric of their art shaken to its very foundation by the refinements of specialism. But may the reverse ultimately be the case, and, like Abou Ben Adhem, "may his tribe increase" and inspiration come from his noble example!

For many of the thoughts and suggestions contained in the present paper I am indebted to Dr. Fulton, that "Guide, Philosopher and Friend" for more than half a score of years, whose example of industry, devotion to duty and uprightness of character has been a lesson and an inspiration to us all. I shall embrace this opportunity of publicly recording my appreciation of his kindness by addressing to him the following letter:

"Bloomfield," Lauraville, Baltimore, May 20, 1913.

Dr. John S. Fulton,
Secretary State Department of Health,
Baltimore, Md.

Dear Dr. Fulton—I am now about to conclude my rather prolix, yet withal affectionate, *billet doux* to the 800 physicians practicing medicine in the counties of Maryland. At your earliest convenience I trust you will do me the courtesy to peruse these pages, hoping their intrinsic merits may be such as to win your approbation.

By no means have I exhausted the subject. Far from it. Indeed, I have merely blazed a more definite trail through the almost trackless waste of ignorance in the reporting of communicable disease. However, if the route which I have laid down herein be devoutly followed, I believe much good will result.

Assuring you that my sole object in preparing this paper is to be of service to you in getting better reports of infectious diseases occurring in the counties of Maryland, I have the honor to be, with expressions of my high personal regard for you and of my abiding interest in the work,

Very sincerely yours,
C. W. G. Rohrer,
Acting Chief, Bureau of Communicable Diseases.

It has seemed fitting to me to round out this little schoolboy "composition" by quoting the stanzas of the late Will Carleton's exquisite poem entitled "The Country Doctor." Doubtless many of you have read it before and have misplaced it or forgotten it. It is a just and glowing tribute to the worth of that greatest of all benefactors to the human race,[49] namely, the country practitioner. The poem is this:

"The Country Doctor.[50]

"There's a gathering in the village that has never been outdone
Since the soldiers took their muskets to the war of 'sixty-one;
And a lot of lumber wagons near the church upon the hill,
And a crowd of country people, Sunday-dressed and very still.
Now each window is pre-empted by a dozen heads or more,
Now the spacious pews are crowded from the pulpit to the door;
For with coverlet of blackness on his portly figure spread,
Lies the grim old country doctor, in a massive oaken bed.
Lies the fierce old country doctor,
Lies the kind old country doctor,
Whom the populace considered with a mingled love and dread.

"Maybe half the congregation, now of great or little worth,
Found this watcher waiting for them when they came upon the earth;
This undecorated soldier, of a hard, unequal strife,
Fought in many stubborn battles with the foes that sought their life.
In the night-time or the day-time he would rally brave and well,
Though the summer lark was fifing, or the frozen lances fell,
Knowing if he won the battle, they would praise their Maker's name,
Knowing if he lost the battle, then the doctor was to blame.
'Twas the brave old virtuous doctor,
'Twas the good old faulty doctor,
'Twas the faithful country doctor—fighting stoutly all the same.

"When so many pined in sickness, he had stood so strongly by,
Half the people felt a notion that the doctor couldn't die;
They must slowly learn the lesson how to live from day to day,
And have somehow lost their bearings—now this landmark is away.
But perhaps it still is better that his busy life is done:
He has seen old views and patients disappearing one by one;
He has learned that Death is master both of Science and of Art;
He has done his duty fairly, and has acted out his part.
And the strong old country doctor,
And the weak old country doctor,
Is entitled to a furlough for his brain and for his heart."

6 East Franklin street.

REFERENCES.

[43]The Baltimore Medical College is the only medical school in this city which still administers the Hippocratic oath. It, however, is not infrequently read in the other medical schools at the introductory lectures.

[44]Instances of one pestilence seemingly preparing the way for another are given by Donaldson on pp. 99 and 100 of his "Review" as follows:

"In 5583 (A. D. 1579) the summer was very moist and rainy, succeeded by a cold, dry north wind about the rising of the dog star; the winter was open and chilling; an epidemic catarrh pervaded all Europe; in June it began in Sicily; in July it existed in Italy; in August it raged in Venice and Constantinople; in September it infested Hungary, Bohemia and Saxony; in October it prevailed on the Baltic; in November it appeared in Norway; in December it ravaged Sweden, Poland and Russia, etc. Its symptoms were a violent fever for four or five days, with pains in the head, straightness of the breast, a severe cough, terminating in profuse sweating. Bleeding and purging, says Reverius, were considered injurious in general. In Rome 4000 persons died of it; in Lubec, 8000; in Hamburgh, 3000, and great multitudes in other places perished by epidemic pestilence. While this deadly catarrh wasted Europe, one of the most destructive plagues ever known began in Grand Cairo. Prosper Alpinus, who lived in that century, has reported the number of deaths from November, 5584 (A. D. 1580), to July, 5585 (A. D. 1581), to have been 500,000. It has been always observed by us that epidemic anginas, quinsies, smallpox, measles, catarrhs and fevers generally precede great and dreadful plagues, as their precursors; for the constitution of the seasons to produce these diseases being continued and increased in its natural or accidental malignancy and powers, will always induce pestilence or plague, as the highest gradation of morbidity in all these distempers which appear to be the same in essence, but different in appearance, only modified by the differences of climate, differences of the seasons, and the differences of the duration and energy of the efficient causes. It carried off in the same year many hundred thousand persons of the poorer class of the population of France and Egypt; it prevailed especially at Laon, in Vermandois, which is much exposed to the burning heat of the sun, and destroyed 6000 persons. The historian Thuanus relates that the crops of that year were plentiful and the sky serene, but he does not tell us the duration of the drought, the gradation of the heat, the suddenness of the changes of temperature, the heat of the days and the cold dampness of the night. The catarrh in those days was distinguished by a chill, or rigour in the lower portion of the spine, which was succeeded by gravedo or dull pain in the head, languor, universal dejection of spirits, and diminution of strength; and when it did not end favorably in five days, it terminated in a fatal fever."

[45]The colonists landed at St. Mary's March 25, 1634, the anniversary of which date we still celebrate as "Maryland Day."

[46]We cannot protect man too well from communicable diseases. Yet, as a rule, those in authority are loth to spend money for such a purpose. Ample provision, however, has been made to protect cattle from tuberculosis, hogs from cholera and swine plague, horses from meningitis, sheep from anthrax, etc.; and the casual

reader is sometimes half inclined to believe there is a modicum of truth in the oft-quoted story concerning the tuberculous mother and the cholera hog, whose moral is, "Be a hog and be worth saving." This is all a mistake, because, in the language of poesy,

"Man is the noblest growth our realms supply,
And souls are ripened in our Northern sky."

[47]Dr. Rush, writing of the influence of a single epidemic upon diseases prevailing at the time, or of the influence of epidemics over each other, makes the following statement on p. 89 of his work on yellow fever:

"The bilious remitting fever which prevailed in Philadelphia in 1780 chased away every other febrile disease, and the scarlatina anginosa which prevailed in our city in 1783 and 1784 furnished a striking proof of the influence of epidemics over each other. In the account which I published of this disease in the year 1789 there are the following remarks: 'The intermitting fever which made its appearance in August was not lost during the month of September. It continued to prevail, but with several peculiar symptoms. In many persons it was accompanied by an eruption on the skin and a swelling of the hands and feet. In some it was attended with sore throat and pains behind the ears. Indeed, such was the prevalence of the contagion which produced the scarlatina anginosa that many hundred people complained of sore throats, without any other symptom of indisposition. The slightest exciting cause, and particularly cold, seldom failed of producing the disorder.' ('Medical Inquiries and Observations,' London, edit., Vol. I, p. 122.")

[48]This humanitarian spirit in physicians is beautifully alluded to in the following quotation from Dr. R. L. Howard's introductory lecture entitled "The Shame and Glory of the Medical Profession," delivered before the Starling Medical College of Columbus, Ohio, on the evening of November 7, 1849:

"Since the medical profession has been thoroughly organized within the last few centuries, whenever any widespreading pestilential calamity has prevailed, when men, women and children by thousands have been swept away as with the besom of destruction by smallpox, plague, yellow fever, or the devouring cholera, who hath stood at his post, jeopardized his own life and braved every danger in order to save or soothe the perishing victim? Though the night be dark, cold and stormy, and the tempest drives its fearful career over the dreary earth, who arises at any and all hours, answers to the call of the poor as well as the rich, the lowly as well as the honorable, the ungrateful vagabond as well as the grateful and cherished friend, and finds his way to the bedside of the sufferer? Let the community answer. We know and confess with shame and indignation that there are dishonorable exceptions to the general rule. We know that there are those among *us* who fled through sheer cowardice from the cholera and scenes of distress and danger. As they deserve, let the "*anathema maranatha*" fall upon their heads. They are traitors to our order, false to their profession, their fellow men, and their God."

[49]Commenting upon the high type of bravery exhibited by physicians in times of deadly epidemics, and the little notice which their heroism receives, Dr. Rush, on p. 339 of his book on yellow fever, has the following to say:

"Narratives of escapes from great dangers of shipwreck, war, captivity and famine have always formed an interesting part of the history of the body and mind of man. But there are deliverances from equal dangers which have hitherto passed unnoticed; I mean from pestilential fevers. I shall briefly describe the state of my body and mind during my intercourse with the sick in our late epidemic. The account will throw additional light upon the disorder and probably illustrate some of the laws of the animal economy."

Dr. Rush then follows with a lucid account of his own labors and sufferings, which extends through twenty-five pages.

[50]Will Carleton died at his home in Brooklyn, N. Y., of pneumonia on December 16, 1912, aged 67 years.

ADDENDA.

1. Since the first part of this article was written Dr. Benjamin F. Shipley, health officer of the Third District, Howard County, has died, at the age of 64 years. His death occurred on June 13, resulting from mitral insufficiency and cardiac dilatation, following a severe attack of influenza. He was succeeded by Dr. John W. Hebb of West Friendship.

2. In checking up the monthly reports of typhoid fever for 1912, a discrepancy of 98 cases of sickness was detected in the figures for the month of October. Adding these to the 1607 cases given in reference No. 41, makes a total of 1705 typhoid cases, and a grand total of 5825 cases of communicable diseases, instead of 5727. By including the 522 county tuberculosis cases, the

total for the year is increased to 6347. (See Annual Report of the State Board of Health for the year 1912).

3. Since writing the foregoing paper a copy of the "Annotated Code of the Public Civil Laws of Maryland," edited by George P. Bagby of the Baltimore Bar, was purchased by the State Board of Health. But I wish to explain that I have followed the old code—that of 1904, the "Public General Laws of Maryland," codified by the late Hon. John Prentiss Poe.

Correspondence.

SCHOOL FOR HEALTH OFFICERS, CONDUCTED BY HARVARD UNIVERSITY AND THE MASSACHUSETTS INSTITUTE OF TECHNOLOGY.

Beginning this fall, Harvard University and the Massachusetts Institute of Technology are to maintain in co-operation a School for Public Health Officers. The facilities of both institutions are to be available to students in the School, and the Certificate of Public Health (C. P. H.) is to be signed by both President Lowell and President Maclaurin.

The object of this School is to prepare young men for public health work, especially, to fit them to occupy administrative and executive positions such as health officers or members of boards of health, as well as secretaries, agents, and inspectors of health organizations.

It is recognized that the requirements for public health service are broad and complicated, and that the country needs leaders in every community, fitted to guide and instruct the people on all questions relating to the public health. To this end, the instruction of the new School will be on the broadest lines. It will be given by lectures, laboratory work, and other forms of instruction offered by both institutions, and also by special instructors from national, state and local health agencies.

The requirements for admission are such that graduates of colleges, or technical and scientific schools, who have received adequate instruction in Physics, Chemistry, Biology, and French or German, may be admitted to the School. The medical degree is not in any way a pre-requisite for admission, although the Administrative Board strongly urges men who intend to specialize in public health work to take the degree of M.D. before they become members of the School for Health Officers.

The Administrative Board which will conduct the new School is composed of Professor William T. Sedgwick, of the Massachusetts Institute of Technology; Professor Milton J. Rosenau, of Harvard, and Professor George C. Whipple, of Harvard. Professor Rosenau, of Harvard, has the title of Director, and the work of the School will be under his immediate supervision.

MARYLAND MEDICAL JOURNAL

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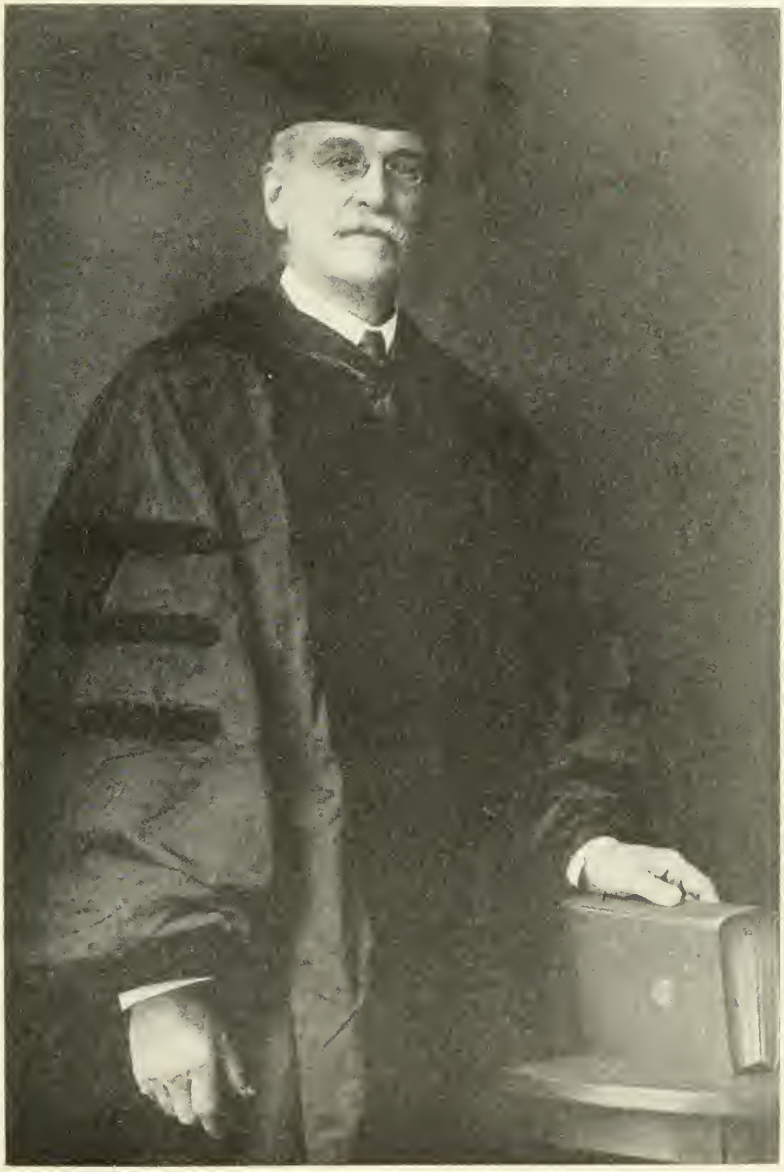
BALTIMORE, OCTOBER, 1913

THE LATE EUGENE FAUNTLEROY CORDELL, A.M., M.D.

The sudden death of Doctor Eugene Fauntleroy Cordell, August 27, 1913, a former editor of the MARYLAND MEDICAL JOURNAL, has removed a unique figure from the medical profession of Maryland. His most valuable legacies undoubtedly have been his unselfish devotion to philanthropic efforts in behalf of those left helpless and his rescue from oblivion of the life, acts, deeds and accomplishments of Maryland medical genii of bygone times. His chief delight and happiness were in doing in a modest and unassuming way something for those in destitute circumstances. The widows and orphans of those physicians to whom he lent a helping hand, and, better still, sympathy in their loneliness and desolation, will sorely miss his cheerful smile and words of hope and encouragement. In order to better care for these unfortunates he founded and financiered The Home for Widows and Orphans of Physicians. Among his other philanthropic efforts in which he took especial pride are the creation of a fund for widows and orphans of physicians, the establishment, together with Doctor Leigh Bonsal and Mr. George Torrance, of the Home for Incurables, and the creation of a permanent endowment fund for the University of Maryland. Doctor Cordell was a man of many noble qualities, a steadfast friend, a firm believer in and supporter of high medical educational standards. He was thoroughly convinced that the doctor should be an educated man, and as a result of this belief, called together the representatives of the Baltimore medical institutions, through which meeting the Association of American Medical Colleges directly resulted. He was a man of the highest ideals, and spoke out his convictions without a least regard of personal consequences. There has never been, and in all probability never will be, another such man in the profession in Maryland. He devoted his life to man, untiringly, ceaselessly, unselfishly giving the best years and efforts of his life to the helping of others. He was an authority on the his-



EUGENE F. CORDELL, A.M., M.D.
1843-1913.

tory of medicine, and especially versed in that of Maryland, and was a prolific writer along these lines, for which services posterity owes him an everlasting debt of gratitude. His Medical Annals of Maryland and Histories of the University of Maryland are priceless heritages which will perpetuate his name as long as our profession exists. Unfortunately, he did not live to see his work fully materialize. But he may console himself with the thought, "We find an unfinished work when we arrive; we leave the work unfinished when we are called hence." Each day marks out our duty for us, and it is for us to devote ourselves to it, whatever it may be, with high purpose and unfaltering courage. Whether we live to enjoy the fruits of our efforts or lay down the work before the victory is won, we know that every well-spoken word has its influence; that no good deed is ever lost. And we know also that no one can count his life on earth as spent in vain if, when he departs, it can be said: "The night is darker because his light has gone out; the world is not so warm because his heart is grown cold in death." Judged by this standard, Doctor Cordell cannot count his life as spent in vain. Though some of his dreams have not fully materialized, he has created a sentiment, and some strong man or woman will take up the tasks which he was so unexpectedly called upon to relinquish. As soldier, physician, historian, teacher, writer, moralist, he sustained his various offices with the approbation of his fellow-man, while he illustrated in his life those graces which adorn the Christian character. He had no patience for the hypocrite, but endeavored to be absolutely fair in his writings by giving credit to whom credit was due. He was exceptionally keen in his estimates of men, a simple, guileless soul, bent on doing his duty as he saw it. Though extremely religious, he never intruded his religious views upon others. No one surely was better prepared to meet the call of his Maker and with better grace answer, "Lord, I come." While living he exemplified by his every act those glorious words of Oliver Wendell Holmes:

"Build thee more stately mansions, O my soul,
As the swift seasons roll;
Leave the low-vaulted past;
Let each new temple, nobler than the last,
Shut thee from heaven with a dome more vast,
Till thee at last are free,
Leaving thine outgrown shell by life's unresting sea."

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Medical Items.

The engagement is announced of Dr. Merle D. McCutcheon, Physicians and Surgeons, class of 1908, of East Liverpool, Ohio, to Miss Louise Alberta Sturtevant. The wedding will take place October 1, 1913, at Westminster Presbyterian Church.

The engagement is announced of Dr. E. DeWitt Simpson, Johns Hopkins Medical School, class of 1912, of Rochester, Minn., to Miss Myrtle Harrell Pearce of Minneapolis, Minn. The wedding will take place shortly. Dr. Simpson is a member of the Mayo clinic of St. Mary's Hospital, Rochester, N. Y.

Dr. Clement A. Penrose, Johns Hopkins Medical School, '97, and family, who have been occupying their cottage at Siasconset, Mass., during the summer months, have returned to their town residence, 21 W. Mount Royal avenue.

The public health exhibit of the Maryland Medical and Chirurgical Faculty opened August 11, at the Y. M. C. A. Building, Frederick, Md., and continued a week. Addresses were made on tuberculosis, alcohol, mental and social diseases, and infant mortality.

Drs. H. O. Reik, Walter A. Baetjer, John Ruhrah, W. I. Moss and W. S. Thayer, all of Baltimore, sailed July 11 on the steamship Kaiser Wilhelm II for Bremen, via Plymouth and Cherbourg. They will return to Baltimore in the fall.

MARRIAGES.

Dr. Charles J. Carey, College of Physicians and Surgeons, '97, of Sykesville, Md., superintendent of the Eastern Shore Hospital, at Cambridge, Md., to Miss Grace Eloise Ridgely, of Carroll county, Md., September 1, 1913, at Sykesville, Md. Immediately after the ceremony Dr. and Mrs. Carey left for Atlantic City. Upon their return they will live in Cambridge.

Leo J. Goldbach, M.D., University of Maryland, '05, to Miss Gertrude Elizabeth Brehm, both of Baltimore, Md., at Baltimore, October 9, 1913.

DEATHS.

Henry M. Emerick, M.D., College of Physicians and Surgeons, '80, of Milton, Pa., died at his home from acute indigestion August 31, 1913, aged 59 years.

Samuel Rozier Catts, M.D., Baltimore Medical College, '06, of Madison, Ind., died at the home of his father in Alexandria, Va., from tuberculosis, August 29, 1913, aged 36 years.

Daniel Aloysius Shay, M.D., Baltimore University, '01, New York University, N. Y., '04, of Brooklyn, N. Y., died in Marlborough, N. Y., from acute nephritis August 21, 1913, aged 37 years.

John W. McPherson, M.D., Baltimore Medical College, '98, of Haw River, N. C., died suddenly at the home of his father, in Liberty, N. C., July 27, 1913, aged 40 years.

Eugene Fauntleroy Cordell, M.D., University of Maryland, '68, M.A. University of Maryland, 1907, Professor of History of Medicine and Librarian, and a former editor of the Maryland Medical Journal, died at his home, 257 West Hoffman street, Baltimore, Md., August 27, 1913, aged 70 years.

William Wyatt Wiley, University of Maryland, '71, of Cumberland, Md., died after a lingering illness at his home in Cumberland, August 27, 1913, aged 64 years.

William A. Jordan, M.D., College of Physicians and Surgeons, '73, died at his home, 601 East Douglas street, Wichita, Kan., from heart disease, August 19, 1913, aged 67 years. Dr. Jordan was one of the founders of St. Francis' Hospital, Wichita, Kan., and later a member of the staff of the Wichita Hospital.

Isaac Newton Boyd, M.D., College of Physicians and Surgeons, '80, of Etters, Pa., died at his home from heart disease August 21, 1913, aged 60 years. Dr. Boyd taught for seven years in the York Haven School, and was for 20 years a practitioner of Goldsboro, Pennsylvania.

David F. Pennington, M.D., Maryland Medical College, '85, of Washington, D. C., died at his home August 16, 1913, from acute gastritis, aged 62 years. Dr. Pennington was for 20 years president of the Masonic Relief Association of Baltimore, Md., and a resident of that city until 1902.

William Henry McCarthy, M.D., College of Physicians and Surgeons, '91, of Boston, Mass., died at his home August 22, 1913, from appendicitis, aged 70 years. Dr. McCarthy was a member of the Massachusetts Medical Society.

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Book Reviews.

THE CARE OF THE INSANE AND HOSPITAL MANAGEMENT. By Charles Whitney Page, M.D., Assistant Physician Hartford Retreat, Connecticut, 1871 to 1872 and 1873 to 1888; Superintendent Connecticut Hospital for the Insane, Middletown, 1898 to 1901; Superintendent Danvers State Hospital, Danvers, Mass., 1888 to 1898 and 1903 to 1910; Member of the American Medico-Psychological Association, the Boston Society of Psychiatry and Neurology, the New England Psychiatric Society, the Massachusetts Medical Society. 1912. Boston: W. M. Leonard.

The present volume is a scientific exposition of the treatment of the insane along humanitarian lines. Stress is laid upon non-mechanical restraint of the insane and conditions essential to its success. Along these lines it also enters very thoroughly into the proper selection of a superintendent, his qualifications and duties, the selection of the assistant physicians and their qualifications, the importance of a well-equipped laboratory, and the part it plays, the management of patients, the attendants and nurses and other vital questions regarding the proper handling of the insane. The underlying tone of the entire volume is to manage those under care with gentleness and kindness rather than by drastic measures. The non-restraint method of caring for the insane is a modern development, but is gaining additional adherents daily, thereby opening up a new regime in the treatment of insanity. Maryland has just passed through a transition in its method of caring for the insane, the State Lunacy Commission having ordered the abolishment of the strait-jacket, etc., in the State institutions, with marked benefit to the physical comfort of the patients, and so far no loss in control over the unfortunate individuals. Doctor Page, through his wide experience in managing the insane, is well qualified to speak as regards the non-restraint method in caring for the insane. What he says is said with the backing of twenty-five years' experience in this line of work. If, as he states, he has found the practical elimination of mechanical restraint a benefit and a blessing to the mentally unbalanced, surely others could employ the same measures with as much satisfaction. Remember the insane are sick people, as well as those suffering from appendicitis, and should command as much sympathy, kindness and care. Nobody can read the present volume without being convinced that in insanity as well as other ills the chief essential to success is humaneness.

EPIDEMIC CEREBROSPINAL MENINGITIS. By Abraham Sophian, M.D., Formerly with New York Research Laboratory. Twenty-three Illustrations. St. Louis: C. V. Mosby Company. 1913. Cloth, $3.00 net.

This monograph of some two hundred odd pages is a distinct addition to our literature on this interesting infectious disease, as it is written by a man who is cognizant not only with the laboratory side but also the practical, he having had experience in the clinical laboratories of New York and in the field in Texas. It is an effort to stimulate further investigations, and thus increase our knowledge concerning this malady. The author, besides

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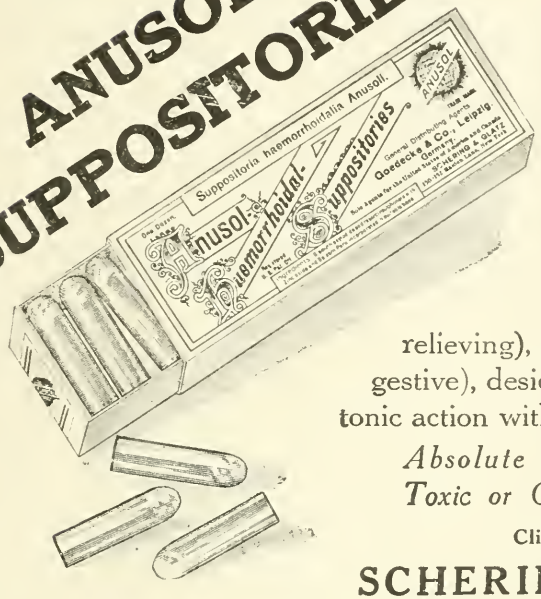

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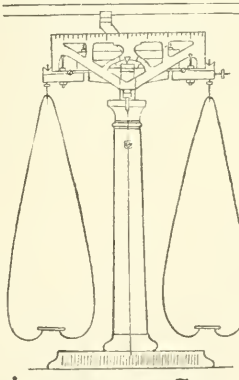

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entering thoroughly into its etiology, distribution, symptomatology, laboratory diagnosis, complications and treatment, especially emphasizes the methods to be employed in controlling an epidemic and the studies on blood-pressure in meningitis.

As a concrete example of the interdependence between laboratory and practice no more beautiful lesson could be adduced than the control of the Texas epidemic. Here all the laboratory theories and experiments were applied practically to the human individual, and the results gained thereby set forth in this book. The organism was not only regained from the cerebrospinal fluid, but also from the nasopharynx, and in the latter location was detected in some instances before the meningitis set in. The author was also able to prove that some people acted as carriers of the affection, and that it was useless to hope for a stamping out of an outbreak until these carrier cases have been recognized, properly quarantined and held in limbo until their throats cease to show the presence of the micro-coccus peculiar to epidemic cerebrospinal meningitis. The author minutely explains the operation of lumbar puncture, the position in which to place the patient, preparation of the site of puncture, route of puncture, level to be chosen, depth of puncture, dangers to look out for and other details of more or less interest, besides a condensed history of the introduction of the specific anti-meningitis serum, its preparation, standardization and prophylactic and curative uses.

As cerebrospinal meningitis of the epidemic form has and will occur in Baltimore and Maryland, it behooves the profession to be prepared to recognize it when it puts in its appearance, and to be fully acquainted with its treatment. As a reliable guide the above volume will be found to be admirably qualified. It treats the subject in a brief manner, still fulsome enough to meet the requirements of the active, busy practitioner, who is compelled through circumstances to get his information with as little loss of time as compatible with a thorough understanding of the disease under investigation. It gives us great pleasure to recommend this volume for that purpose.

The Narcotic Drug Diseases and Allied Ailments. Pathology, Pathogenesis and Treatment. By George E. Pelty, M.D., Memphis, Tenn., Member Memphis and Shelby County Medical Society, Tennessee State Medical Association, Tri-State Medical Association of Mississippi-Arkansas-Tennessee; also Mississippi Valley Medical Association, Southern Medical Association and of the American Society for the Study of Alcohol and Narcotic Diseases. Illustrated. 1913. Philadelphia: F. A. Davis Company. Cloth, $5.00 net.

The profession is just beginning to realize that the habitues of drugs are the victims of disease and as such entitled to our commiseration, pity and help. In many instances those addicted to the use of opium, alcohol, etc., are the victims of circumstances over which they had no control. An intractable neuralgia calls for relief, the victim is beside him or herself with pain; the hypodermic syringe, after perhaps hours of suffering, gives the desired relief; after the influence of the drug wears off the pain recurs, maybe in a more aggravated form than before; the sufferer calls again for release from pain; another dose of morphia,

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and thus the habit, once started, gains greater and greater control over the user. Such is oftentimes the history one obtains from the narcotic victims. Under the circumstances is it fair to condemn these wretches? They are miserable enough already, and instead of condemnation, need sympathy and help. It is with this object in view that Pelty has written his book on the drug diseases. He treats the narcotic habit as it really is, namely, a disease, and as a disease he tries to impress upon the reader the importance of detecting the causative factor in the production of the habit. When one stops to consider the number who are addicted to one or another form of drug, one can only realize the value of Pelty's production, which treats the subject in a rational and scientific manner. Besides entering into the historical aspect of the subject, he also very fully and thoroughly depicts the symptoms of the user of opium, and the symptoms arising when the opiate is withdrawn, as well as the treatment. In the latter part of the book he devotes considerable space to the cocaine and alcoholic users, delirium tremens, and the treatment of acute ailments occurring in alcoholic subjects.

Golden Rules of Diagnosis and Treatment of Diseases. Aphorisms, Observations and Precepts on the Method of Examination and Diagnosis of Diseases, with Practical Rules for Proper Remedial Procedure. By Henry A. Cables, B.S., M.D., Professor of Medicine and Clinical Medicine of the College of Physicians and Surgeons; Consultant at Jefferson Hospital; formerly House Physician at Alexian Brothers' Hospital, St. Louis. Second edition, revised and rewritten. St. Louis: C. V. Mosby Company. 1913. Cloth, $2.25.

The principal characteristic of the present edition, as of the first, is the brevity of statement and compactness of description of any given disease. This feature renders it possible for the busy practitioner to readily and quickly look up a subject with the least expenditure of time and energy. The present volume is full of useful hints and aids which the author has found of use in his practice. It is just the thing for quick reference, as it treats each subject with enough fullness to make it intelligible, but with sufficient brevity to meet the most exacting demands of a first-aid textbook. We predict for it as great a popularity as its predecessor, as it is written in the same simple diction, and the author has been fully alive to the necessity of keeping his statements in accord with modern medical thought. It is, therefore, entirely dependable for the purposes for which it is intended.

Tuberculin in Diagnosis and Treatment. By Francis Marion Pottenger, A.M., M.D., LL.D., Medical Director of the Pottenger Sanatorium for Diseases of the Lungs and Throat, Monrovia, Cal. With 35 illustrations, including one plate in colors. St. Louis: C. V. Mosby Company. 1913. Cloth, $3 net.

The status of tuberculin in diagnosis and treatment has been frequently written upon, but with more or less indefinite results when it comes to the purposes of the general reader, who before he finishes the article is lost in a haze of intricacies. Still much has been learned of the uses of this agent of late both by experi-

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mentation upon the animal and observation upon the man. It is therefore proper that Dr. Pottenger, who has had an enormous experience with this drug, present his conclusions to the medical profession, so that the great body of general practitioners be in a better position to judge of its uses. This monograph of a little over 200 pages is devoted entirely to the various phases of tuberculin in diagnosis and treatment as found useful and beneficial in the hands of Dr. Pottenger. It is a book that should be in the hands of every general practitioner, as it minutely and accurately describes the technique when using tuberculin and those cases in which it may be looked for to do good. In the hands of Dr. Pottenger it has given excellent results; consequently he may be a little overenthusiastic. Withal he speaks very conservatively, and does not lead one to believe that it is a cure-all in this most dreaded of diseases. After a careful perusal of the pages of the above volume one will be in a much better position to understand the uses of tuberculin in diagnosis and treatment of tuberculosis. We take pleasure in commending it to the medical profession.

A Compend on Bacteriology, Including Animal Parasites. By Robert L. Pitfield, M.D., Pathologist to the Germantown Hospital; Late Demonstrator of Bacteriology at the Medico-Chirurgical College, Philadelphia; Visiting Physician to St. Timothy's Hospital and Chestnut Hill Hospital, Philadelphia. Second edition, with 4 plates and 85 other illustrations. Philadelphia: P. Blakiston's Son & Co. 1913. Cloth, $1 net.

This little book is exceptionally well adapted to the needs of the student when used in conjunction with larger textbooks. It is also exceptionally suited to graduates when preparing for examinations, either school or State boards. Though spoken of as a compend, it is really a little textbook; though brief, still it contains the essentials, and a person well grounded in the elements of bacteriology will find it a useful guide for the purposes mentioned above.

Ophthalmology for Veterinarians. By Walter N. Sharp, M.D., Professor of Ophthalmology in the Indiana Veterinarian College; Ophthalmic Surgeon to the Indiana City Hospital. 12mo, 210 pages; illustrated. Philadelphia and London: W. B. Saunders Company. Baltimore: The Medical Standard Book Co. 1913. Cloth, $2 net.

Here is a book every veterinarian should possess. It is practical, written in an easy style and handsomely illustrated, some of which are in colors. From every aspect it is excellently gotten up, and every practitioner of veterinary surgery should become thoroughly familiar with its contents. It takes up in a systematic manner the anatomy of the eye, examination of the eye, diseases of the lids, operations on the lids, diseases of the lachrymal apparatus, muscles of the eyeball, diseases of the conjunctiva, diseases of the cornea, diseases of the iris and ciliary body, diseases of the retina and choroid, diseases of the optic nerve, diseases of the lens, operations for cataract, recurrent ophthalmia, glaucoma, injuries of the globe, fracture of the orbit, parasites of the eye, the principles of

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vision, errors of refraction, medicines used in ophthalmic treatment.

The book is principally based upon the course of lectures delivered by the author to the senior class of the Indiana Veterinary College, and lays especial emphasis upon external diseases of the eye, as these diseases are the principal eye affections attacking animals. We are especially pleased to see a book of this character, as it shows a trend toward a better and more scientific education of the veterinarian. It is such books which awaken a pride in a profession and points out the way to its elevation into a higher and fuller usefulness.

Solidified Carbon-Dioxide. In the Successful Treatment of Cutaneous Neoplasms and Other Skin Diseases, with Special Reference to Angioma, Epithelioma and Lupus Erythematosus. Fully illustrated. By Ralph Bernstein, M.D., Philadelphia, Pa., Clinical Instructor in Skin Diseases, Hahnemann Medical College, Philadelphia, Pa.; Consulting Dermatologist to the Women's Southern Homeopathic Hospital, Philadelphia, Pa.; Consulting Dermatologist to the J. Lewis Crozer Hospital and Home for Incurables, Chester, Pa.; Consulting Dermatologist to the House of Detention for Juveniles, Philadelphia, Pa.; Dermatologist to West Philadelphia General Homeopathic Hospital and Dispensary; Dermatologist to Hahnemann Hospital Dispensary, Philadelphia, etc. 1912. Cloth. Hammond, Ind.: Frank S. Betz Company.

The appearance of this booklet is indeed timely, as lately a great deal of interest has been aroused in the medical profession as regards the uses to which the carbon-dioxide snow can be put to and how to employ it. That it is a valuable agent in the removal of skin blemishes of one sort or another has now become generally accepted, but there are yet many who do not know how to get it or how to employ it even if they have any at hand. This little book supplies that deficiency. It gives full and explicit directions in what cutaneous diseases it is valuable, and, of more importance to the practitioner, how to apply the snow. Added interest and usefulness is given to the book in that the author includes the reports of a number of cases treated by him by solidified carbonic acid. It will be found by the general practitioner a handy book to have around.

The Surgical Clinics of John B. Murphy, M.D., at Mercy Hospital, Chicago, June, 1913. W. B. Saunders Company, Philadelphia and London. Baltimore: The Medical Standard Book Company. Published Bi-Monthly. Paper, $8 per year.

The present number of Murphy's Clinics is up to the standard of its predecessors. In fact, it contains a greater wealth of material than a number of its predecessors. In this number are to be found discussions by one of the greatest surgical teachers in the world of his methods in the treatment of bony ankyloses, dislocated cartilages, procidentia uteri, cholecystitis, bone fractures, arthroplastics, tenoplasty, etc., and the operation of bone grafting for the cure of Pott's Disease, as devised by Dr. F. H. Albee, of New York City, including a talk by Dr. Albee at Mercy Hospital Clinic.

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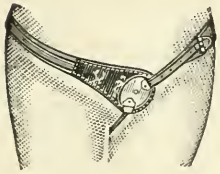

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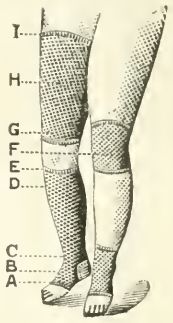

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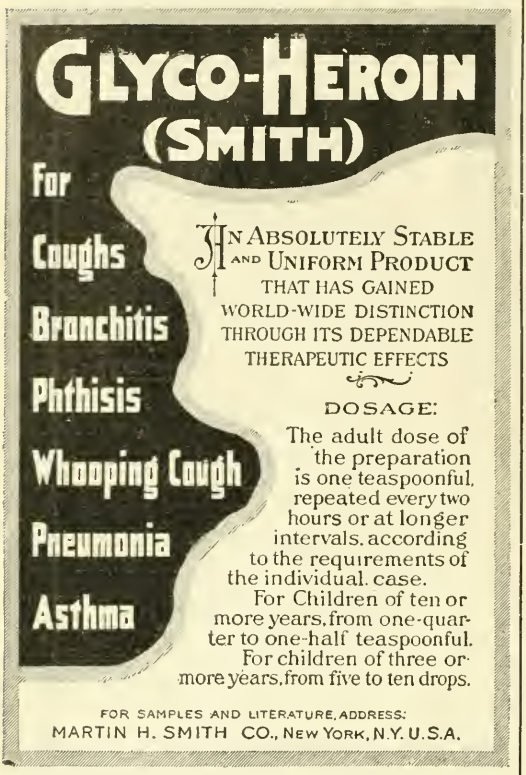
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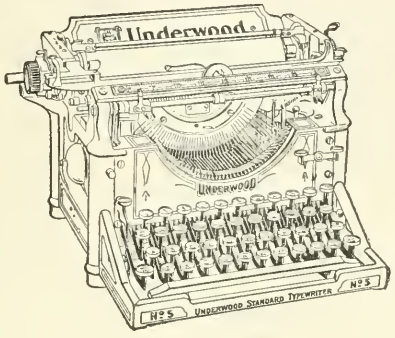

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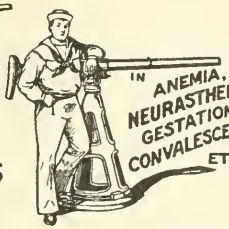

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